U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 11 February 2004

In the Matter of

HAROLD DENNISON
Claimant

Case No. 2003-BLA-05909

v.

PLOWBOY COAL CO., INC.
Employer

and

CONNECTICUT INDEMNITY COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-In-Interest

W. Andrew Delph, Jr., Esq.
Norton, VA
For the Claimant

Christopher Pierson, Esq.
Pittsburgh, PA
For the Employer

Before: JEFFREY TURECK
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS[1]

This is a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901 *et seq.* (hereinafter referred to as "the Act"). This claim was filed on September 14, 2001 and the Office of Workers' Compensation ("OWCP") granted benefits on January 8, 2003 (DX 1, 30).Plowboy

[1] Citations to the record of this proceeding are abbreviated as follows: CX – Claimant's Exhibit; EX – Employer's Exhibit; and DX – Director's Exhibit.

Coal Company ("Employer") was designated as the responsible operator for this claim and opposed Harold Dennison's ("Claimant") entitlement to benefits (DX 12, 15). In response to the OWCP's award of benefits, Employer requested a hearing (DX 32).

A formal hearing was scheduled for September 3, 2003 in Abingdon, Virginia. At the request of the parties, this hearing was canceled and the case is being decided on the record (*Claimant's Motion for Hearing on the Record*; *Employer's August 27, 2003 Letter*; *Order Canceling Hearing and Closing Record*). The record closed on September 10, 2003. The issues contested were the existence of complicated coal workers' pneumoconiosis and the cause of Claimant's total disability (*Closing Memorandum on Behalf of Responsible Operator,* at 4, 15-21). Based on the evidence contained in the record of this proceeding, I find that the Claimant is not entitled to benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Claimant is 59 years old, divorced, and has no dependents under the Act.[2] Claimant worked as a coal miner in Virginia for approximately 16 years, the last 3 of which were spent working for Employer (DX 2, 4, 30; *Closing Memorandum on Behalf of Responsible Operator*, at 3). He performed numerous jobs in the mines including miner operator, shuttle car operator, and scoop operator (DX 2, 3, 6). His last job was as a cutting machine operator which required that he lift and carry heavy items on a daily basis (DX 3). He was laid off from his last coal mine employment in 1990 (DX 21, report of Dr. Hippensteel (July 16, 2002); DX 29; EX 1; EX 2, at 5).[3] Prior to his coal mining work, Claimant was a truck driver for the United States Army for approximately four years (DX 2).

At the time that the record closed Claimant was experiencing deteriorating health. He began experiencing breathing problems and arthritic symptoms in the late 1990s (CX 1; DX 6, 21; EX 1; EX 2, at 7). He was diagnosed with rheumatoid arthritis in 1999 and evidences rheumatoid nodules on his outer extremities (CX 1; EX 2, at 7). Despite having a prescription for an inhaler, Claimant is not currently taking any prescribed medications (EX 1; *see* CX 1).

Claimant has a long history of smoking. Due to the absence of testimony from the Claimant, the smoking histories found in Claimant's various medical records must be relied on to determine how much he smoked. But these medical records are not consistent. Dr. Fino reported that Claimant smoked a half pack of cigarettes a day from 1958-89 (EX 1, 2); Dr. Rasmussen reported that Claimant has smoked since 1958 and still smokes 1/3 – 1/4 pack of

[2] Because Claimant is under no obligation to, and does not, provide any monetary support to his divorced spouse (DX 1), the divorced spouse is not a dependent under the Act (*see* 20 C.F.R. §§725.206-207 (2003)).

[3] Claimant's black lung claim indicates that he left work in 1991 because of breathing problems and arthritis (DX 1). However, many of Claimant's medical records indicate that Claimant does not recall having arthritic symptoms or breathing problems until 1999 (*see, e.g.,* CX 1; DX 6, 21; EX 1; EX 2, at 5). Additionally, numerous physicians uniformly report in their opinions that Claimant stopped working because he was laid off (*see, e.g.,* DX 6, 21; EX 1; EX 2, at 5).

cigarettes daily (CX 1); Dr. Forehand's report listed a history of smoking a quarter pack a day from 1970-90 (DX 6); and Dr. Hippensteel reported a history of smoking for only 10-12 years at a rate of a half pack of cigarettes a day starting in 1974 (DX 21). But Dr. Hippensteel also reported the results of a carboxyhemoglobin test. He reported that Claimant's carboxyhemoglobin level was consistent with smoking more than a pack of cigarettes a day (DX 21).

It is clear that the Claimant has not been candid in reporting his smoking history. I find that Claimant began smoking in 1958, at the age of 14, because both Dr. Rasmussen, whose report was submitted by the Claimant, and Dr. Fino reported this as the date Claimant began smoking, and he is still smoking. Since he acknowledged on a couple of occasions that he smoked as much as a half pack a day, and the carboxyhemoglobin test indicates that he is currently smoking at least a pack a day, I find that the Claimant has smoked between a half pack and one pack of cigarettes daily and has for approximately 45 years.

Since the claim was filed after January 19, 2001, the regulations contained in 20 C.F.R. §718 as amended are applicable.[4] In order to be eligible for benefits under that Part of the regulations, Claimant must prove that he has pneumoconiosis arising out of his coal mine employment and that he is totally disabled because of this pneumoconiosis (§718.204(a)). Employer has stipulated that Claimant has simple pneumoconiosis, that this pneumoconiosis arose out of Claimant's coal mine employment and that Claimant is totally disabled (*Closing Memorandum on Behalf of Responsible Operator,* at 4). Therefore, to receive benefits Claimant must prove that his total disability arose out of his pneumoconiosis (§718.204(a)).

The medical opinions in evidence uniformly state that the Claimant has a totally disabling pulmonary impairment. The issue is whether that impairment is related to the Claimant's coal mine employment. This issue turns on whether the Claimant has complicated coal workers' pneumoconiosis, in which case his impairment is irrebuttably presumed to arise from his coal mine employment (*see* §718.304); or whether his impairment is due to rheumatoid nodules in the lungs. When a coal miner has rheumatoid nodules in the lungs, the condition is called Caplan's syndrome (*see* DX 29, at 7; EX 2, at 16).[5] Finally, the question of whether Caplan's syndrome is pneumoconiosis under the Act must be addressed.

To establish the irrebutable presumption of entitlement to benefits under §718.304, *i.e*., to prove the existence of complicated pneumoconiosis, the evidence must prove that the "miner is suffering . . . from a chronic *dust disease* of the lung which: (a) When diagnosed by chest x-ray . . . yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C . . ." (emphasis added). It is undisputed that the Claimant has numerous Category A, B and/or C size opacities in his lungs. But large opacities in the lungs may be indicative of many different diseases, including complicated pneumoconiosis and

[4] All of the regulations cited in this decision are contained in Title 20 of the Code of Federal Regulations.

[5] In this decision, when referring to coal miners the terms "rheumatoid nodules in the lungs" and "Caplan's syndrome" will be used interchangeably.

rheumatoid nodules. The issue is whether the opacities found on Claimant's x-rays and CT scans result from Claimant's exposure to coal dust.

Medical Evidence

The record contains the reports of several doctors. Several of these reports are x-ray or CT scan readings. It is significant that all of the doctors' opinions based solely on x-ray interpretations are ambiguous. Although they all note the presence of large opacities, none of them are sure of the source of the opacities. Dr. Wolfe is a board-certified radiologist and a B-reader (a Government-certified expert in interpreting x-rays for pneumoconiosis) (DX 21, Dr. Wolfe's x-ray reading (February 25, 2002)). He read Claimant's February 25, 2002 x-ray as showing category 1/1 simple pneumoconiosis and found a 2.5 centimeter Category A opacity (*id.*). He noted that the large opacity in Claimant's right upper lobe might be from pneumoconiosis but could also have resulted from other causes such as pulmonary metastisis (*id.*).

Dr. Patel is a board-certified radiologist and a B-reader and also provided an ambiguous x-ray reading (CX 1, Dr. Patel's x-ray reading (May 6, 2003)). He found category 1/0 simple pneumoconiosis and several large masses present on Claimant's May 6, 2003 x-ray (*id.*). He stated that he could not conclusively determine whether the large masses he found were "category B large opacities, rheumatoid nodules, granulomas, or fungal disease" (*id.*).

Dr. Saha read an April 2, 2002 CT scan and also found large opacities (DX 28, Dr. Saha's report (April 2, 2002)). He reported that the large opacities that he found in this CT scan appeared benign and were calcified, concluding that they favored a finding of "some kind of benign disease process including granulomatous disease or any underlying systemic disease" (*id.*).

Dr. Hashem read a March 26, 2002 x-ray and compared his reading with a February 25, 2002 x-ray (DX 28). He notes the presence of "multiple pulmonary nodules . . . with [the] largest one in [the] right upper lobe" but fails to chronicle the size of these nodules (*id.*). He also notes that this reading is consistent with the February x-ray. Throughout his entire reading, Dr. Hashem makes no mention of complicated coal workers' pneumoconiosis nor does he discuss the etiology of the pulmonary nodules present on Claimant's March 26, 2002 x-ray.

The only other physician whose opinion is based solely on x-ray/CT scan evidence is Dr. Deponte. Dr. Deponte is board certified in diagnostic radiology and is a B-reader (CX 2, 3; DX 27). She found that Claimant's February 25, 2002 and July 29, 2002 x-rays displayed category B opacities including a 3.5 centimeter opacity in Claimant's right upper lobe (DX 27; CX 2; CX 3, at 10-11). Although she found a category B opacity on both occasions, she noted on each reading that "carcinoma, especially in the large (3.5 cm)[right] upper lobe nodule" should be ruled out (*id.*). Dr. Deponte was deposed, but her deposition was limited to the July 29, 2002 x-ray since she did not interpret the February 25, 2002 x-ray until two months after the deposition (*see* CX 3). In that deposition, she testified that Claimant's x-ray findings were consistent with

complicated coal workers' pneumoconiosis (*id*. at 11). But she testified that the large opacity was also consistent with cancer (*id.* at 15).

All of the other physicians who offered opinions in this case based their opinions not only on x-ray/CT scan evidence but they also examined the Claimant. Perhaps the most probative of these reports are the two prepared by Dr. Almatari of the Stone Mountain Health Services (DX 28.) Dr. Almatari's qualifications are not in the record. Dr. Altamari first examined the Claimant on March 26, 2002, noting that Claimant's attorney referred him for a black lung evaluation. Despite the fact that the examination was conducted on the Claimant's behalf and the x-ray showed multiple pulmonary nodules, Dr. Altamari did not diagnose pneumoconiosis. Rather, noting the multiple nodules on Claimant's hands, elbow, right knee and ankles, Dr. Altamari diagnosed rheumatoid arthritis and found that the nodules in Claimant's lungs were most likely caused by his arthritis. He next examined the Claimant on April 23, 2002. For this examination a CT scan was conducted. Dr. Altamari stated that the CT scan showed pulmonary nodules in both lungs, but he added that these nodules had decreased since March 26th. Since it is axiomatic that coal workers' pneumoconiosis is a permanent condition which may be progressive but does not improve, that Dr. Altamari noted a decrease in Claimant's pulmonary nodules is a strong indication that those nodules are not the result of complicated coal workers' pneumoconiosis.

Dr. Forehand examined Claimant on February 27, 2002 (DX 6) for the Department of Labor (DX 9; *see* DX 6, at 3). Dr. Forehand is a B-reader (a government certified expert in interpreting x-rays for pneumoconiosis), but his medical specialty is not listed in the record. During this examination he performed a pulmonary function test ("PFT"), an arterial blood gas study ("ABG"), and an electrocardiogram ("EKG") and took a chest x-ray (DX 6). Dr. Forehand found a 2.5 centimeter by 3 centimeter mass in Claimant's right upper lung zone (DX 6). Based on these findings, he diagnosed Claimant with complicated pneumoconiosis.

Dr. Forehand's opinion is not probative. First, although he diagnosed complicated pneumoconiosis, he indicated that malignancy, tuberculosis, or rheumatoid lung disease still had to be ruled out (DX 6). Accordingly, it is unclear whether complicated pneumoconiosis was just a working diagnosis until these other conditions could be ruled out or whether these were concurrent diagnoses. In the section of the black lung examination form where the physician is supposed to explain his opinion, Dr. Forehand's explanation ends in mid-sentence. Therefore, Dr. Forehand's actual diagnosis is ambiguous. Second, his diagnosis of complicated pneumoconiosis is based upon the belief that Claimant smoked only 1/4 of a pack of cigarettes daily for 20 years and that he had 33 years of coal mining employment. That he based his opinion on a highly inflated coal mining employment history and a smoking history which was seriously understated raises questions regarding the validity of his opinion. Third, Dr. Forehand considered that Claimant may have rheumatoid lung disease, but he failed to explain why that, rather than complicated pneumoconiosis, was not his primary diagnosis. Since he was aware that the Claimant has arthritis, his failure to explain why the large opacities he saw were lesions of pneumoconiosis rather than rheumatoid nodules is a major deficiency. I find that Dr. Forehand's opinion has too many serious deficiencies to be credible.

Dr. Hippensteel is a board-certified pulmonary specialist and a B-reader (DX 21, Dr. Hippensteel's report and *curriculum vitae*). He examined Claimant on May 14, 2002. During this examination he conducted a PFT, an EKG, and an ABG, and took a CT scan and chest x-ray. He found category 1/0 simple pneumoconiosis and multiple large lesions on Claimant's x-ray. In this reading he notes that the large opacities are "suspicious for Caplan's syndrome or granulomatous disease" and that they "[do] not look like complicated progressive massive fibrosis" (*id.*) Dr. Hippensteel also found large opacities present on Claimant's May 14, 2002 CT scan. He noted that these large opacities "best fit with rheumatoid disease in the lungs and could represent Caplan's syndrome" and that they "do not look like progressive massive fibrosis from pneumoconiosis" (*id.*). He explained that the lesions were widely dispersed "with minimal abnormalities referable to simple pneumoconiosis and no distinct evidence of coalescence of smaller opacities into large opacities on chest x-ray or CT scan" (*id*. at 4). He also cites the mild obstruction which becomes normal post-bronchodilator without evidence of restriction and normal gas exchange at rest as findings which are inconsistent with complicated pneumoconiosis (*id*.). In drafting his medical report he also reviewed Dr. Forehand's report and Drs. Forehand, Wolfe and Barritt's x-ray readings.[6] He noted that Claimant had 15 years of coal mine employment and a twenty-two year smoking history of a half pack of cigarettes a day.

In his report Dr. Hippensteel thoroughly discussed why the opacities present in Claimant's x-ray and CT scan were not progressive massive fibrosis (complicated pneumoconiosis). He concluded that the opacities were evidence of rheumatoid disease and that his rheumatoid disease is the sole cause of Claimant's total disability. Dr. Hippensteel's medical opinion is well reasoned and based upon an accurate coal mine employment history. While he reports an understated smoking history, it does not appear that this inaccuracy would have changed his opinion regarding whether Claimant's coal workers' pneumoconiosis caused his total disability because, if anything, an understated smoking history would have led him to rely less on cigarette smoking as the cause of Claimant's impairment. Dr. Hippensteel's medical opinion is thorough and well reasoned; therefore, I find that it is entitled to great weight.

Dr. Fino is board-certified in pulmonary medicine and is a B-reader (EX 2, at Exhibit A). He examined Claimant on September 26, 2002 (EX 1). During the course of this examination he took a CT scan and an x-ray of Claimant's chest and performed a PFT and an ABG (*id.*). Dr. Fino also read Claimant's February 25, 2002 and May 14, 2002 x-rays (*id.*) He found .5 – 2 centimeter opacities on all three x-rays that he read (EX 1). He reported, in these readings, that the opacities were "consistent with rheumatoid nodules" and notes in his report that rheumatoid nodules caused the large opacities indicated in all of his readings of Claimant's x-rays and were responsible for Claimant's total disability (*id.*). Dr. Fino also read Claimant's May 14, 2002 CT scan and found large opacities (EX 1). He reported that these large opacities also "represent nodules that are due to [Claimant's] rheumatoid arthritis" (*id.*). He explained that the larger opacities present in Claimant's x-rays and CT scan are not consistent with pneumoconiosis, rather they are rheumatoid nodules (*id*.). Further, he reported that the Claimant's

[6] Dr. Barritt read the x-ray taken with Dr. Forehand's examination for quality and for diseases other than pneumoconiosis (DX 10). According to Dr. Hippensteel, who can read "doctorese" better than I can, Dr. Barritt found possible metastatic cancer and emphysema. Dr. Wolfe also read Dr. Forehand's x-ray, which he interpreted as showing category 1/1 simple pneumoconiosis and a large mass in the right upper lobe, type A, which "could result from cause other than pneumoconiosis including pulmonary metastisis." (DX 21).

pneumoconiosis, together with Claimant's smoking history, caused only a mild obstructive ventilatory abnormality that "is not clinically significant . . . [and does] not caus[e] an impairment or disability" (EX 1). He came to this conclusion based upon the results of the PFT that he conducted and Dr. Hippensteel's May 14, 2002, PFT results (*id.*).

Dr. Fino expanded upon his reasoning for diagnosing rheumatoid nodules rather than complicated pneumoconiosis at his May 7, 2003 deposition (EX 2). Among the points made by Dr. Fino were the following: Claimant's breathing problems and rheumatoid arthritis started at the same time; Claimant has rheumatoid nodules in his joints which are similar to the nodules in his lungs; and Claimant has 10-12 large opacities in his lungs, whereas with complicated pneumoconiosis a miner might have two or three large opacities at most (EX 2, at 11-13).

Dr. Fino's opinion is the most detailed and well-explained in the record, and his diagnosis of rheumatoid arthritis rather than complicated pneumoconiosis is entitled to great weight.

Finally, there is the report of Dr. Rasmussen (CX 1). Dr. Rasmussen conducted a comprehensive pulmonary examination on May 6, 2003. In addition, he had an x-ray taken which was interpreted by Dr. Patel as showing category 1/0 simple pneumoconiosis and category B opacities which Dr. Patel attributed to complicated pneumoconiosis, rheumatoid arthritis, granulomatas or fungal disease. Dr. Rasmussen stated that the large opacities were due to either complicated pneumoconiosis or Caplan's syndrome (*id*. at 3).

Based on all of this evidence, I find that the large opacities in the Claimant's lungs are rheumatoid nodules rather than complicated pneumoconiosis. Dr. Fino's opinion is by far the most probative in the record, and it is supported by Dr. Altamari and Dr. Hippensteel's opinions. Further, although other doctors offered other possible causes of the large opacities, none of their opinions were unambiguous. Even Dr. Rasmussen conceded that the opacities could be due to Caplan's disease.

However, finding that the Claimant has rheumatoid nodules or Caplan's disease rather than complicated pneumoconiosis does not end the inquiry into the applicability of the irrebutable presumption. For the Claimant contends that Caplan's syndrome is a form of coal workers' pneumoconiosis, in which case the Claimant still would invoke the irrebutable presumption of entitlement to benefits.

Claimant cites the testimony of Dr. Rasmussen that Caplan's Syndrome is a form of pneumoconiosis (CX 1, at 3). In addition, Claimant quotes from page 181 of The Merck Manual of Medical Information Home Edition (1997) that "Caplan's syndrome [is] a rare disorder that can affect coal miners who have rheumatoid arthritis[. L] arge round nodules of scarring develop quickly in the lung. Such nodules may form in people who have had significant exposure to coal dust, even if they don't have black lung" (*Brief in Support of Award of Benefits,* at 5-6). The regulations define pneumoconiosis as "a chronic dust disease of the lung and it sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" (§718.201(a)). The regulations divide coal workers' pneumoconiosis into two categories, clinical and legal.

> "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment

(§718.201(a)(1)). "'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment . . .includ[ing] any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment" (§718.201(a)(2)). Since the regulations do not specifically enunciate that Caplan's syndrome is a form of pneumoconiosis, it is necessary to look at the medical evidence to determine whether it is "a chronic dust disease of the lung and its sequelae . . . arising out of coal mine employment" (§718.201(a)).

Only Dr. Fino and Dr. Rasmussen discuss whether rheumatoid nodules in the lungs is a dust disease arising out of coal mine employment (CX 1; DX 29[7]; EX 2). Dr. Rasmussen is board-certified in internal and forensic medicine (CX 1, Dr. Rasmussen's *curriculum vitae*). In his May 6, 2003 report, he notes that "Caplan's syndrome is a form of coalworkers' pneumoconiosis with rheumatoid arthritis, often causing progressively severe disabling and ultimately fatal lung disease." (*Id*. at 3) However, Dr. Rasmussen does not cite any medical literature to support this assertion. His report provides no further discussion on the etiology of rheumatoid nodules in the lungs.

Dr. Fino is board-certified in pulmonary medicine (DX 29). In his October 18, 2002 medical report and May 7, 2003 deposition, he noted the term Caplan's syndrome is used when a *coal miner* is diagnosed with rheumatoid nodules in the lungs (DX 29; EX 2, at 16). When a non coal miner is diagnosed with rheumatoid nodules in the lungs it is simply called rheumatoid nodules (*see* DX 29; EX 2, at 16). Dr. Fino testified that there is no clinical difference between rheumatoid nodules in the lungs and Caplan's syndrome (EX 2, at 17). Dr. Fino explained that Dr. Benedek coined the term Caplan's syndrome in the 1960s and that he trained under Dr. Benedek in the 1970s and 1980s (DX 29). In Dr. Benedek's study, rheumatoid nodules in the lungs "occurred more frequently in miner's than nonminers;" however, the increase was not statistically significant, and neither "he nor anyone else since then could say with any scientific certainty whether coal dust caused it" (EX 2, at 17-18). "There may be a cause-and-effect relationship. It may just be by chance. We don't know" (*id*. at 18). In Dr. Fino's opinion, rheumatoid arthritis, which causes the rheumatoid nodules necessary for a diagnosis of Caplan's syndrome, "is an immunologic disease resulting in the destruction of the joints of the body" and that "[t]here is *no* increased incidence of rheumatoid arthritis because one is a coal miner" (DX 29 (emphasis added)). He also was not of the opinion that coal dust aggravates rheumatoid arthritis (EX 2, at 18-19).

It is the Claimant's burden to establish that he is totally disabled due to pneumoconiosis. In this instance, it is his burden to establish that he has complicated pneumoconiosis, which in

[7] DX 29 and EX 1 both contain Dr. Fino's October 18, 2002 report.

turn would invoke the irrebutable presumption that his total disability is due to pneumoconiosis. Dr. Fino's thorough discussion that Caplan's syndrome is not pneumoconiosis is much more probative than Dr. Rasmussen's one sentence explanation that it is pneumoconiosis. Aside from Dr. Rasmussen's report, there is no evidence in the record that the medical community recognizes Caplan's syndrome as a form of pneumoconiosis.[8] Based upon Dr. Fino's testimony, I find that Caplan's syndrome does not fall within the definitions of either legal or clinical pneumoconiosis. Further, the evidence does not establish that Caplan's syndrome is a "chronic dust disease or impairment and its sequelae arising out of coal mine employment" (§718.201(a)(2)).

Substantial Contributing Cause

Claimant can also show that pneumoconiosis caused his total disability with documented and reasoned physicians' opinions that his pneumoconiosis is a "substantially contributing cause" of his total disability (*see* §718.204(c)(1)-(2)). Pneumoconiosis is a substantially contributing cause if it "[h]as a material adverse effect on the miner's respiratory or pulmonary condition . . . or [it] [m]aterially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment" (§ 718.204(c)(1)(i)-(ii)). The Fourth Circuit holds that a Claimant is not eligible for benefits if the Claimant does not show that "pneumoconiosis is a contributing cause [of the] total disability" (*Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994)).

The only doctors who opine that Claimant's pneumoconiosis is a contributing cause to his totally disabling pulmonary impairment are Drs. Forehand and Rasmussen. But both of their opinions are based on their diagnoses of complicated pneumoconiosis, and I have found that the evidence does not prove that the Claimant has complicated pneumoconiosis. While Dr. Hippensteel and Dr. Fino found that Claimant suffers from simple pneumoconiosis, both found that the Claimant's total pulmonary disability is due solely to Caplan's syndrome, a condition which arises from rheumatoid arthritis (EX 1; DX 21). Because I previously found that both of these physicians' opinions regarding the etiology of Claimant's total disability are credible, and there is no other credible medical evidence regarding this etiology, I find that Claimant has not established that his simple pneumoconiosis contributes to his total disability.

In sum, I find that Claimant has failed to establish that his totally disabling pulmonary impairment arises out of his coal mine employment, and benefits must be denied.

[8] The quote from the Merck Manual cited in Claimant's brief is not evidence. Although learned treatises may be admitted into evidence under the informal evidentiary rules which apply to black lung claims (as they can under more formal rules (*see* 29 C.F.R. 18.803(18)), a proper foundation establishing its acceptance by the medical community as a reliable authority is necessary. Claimant did not establish the proper predicate. The only physician questioned about the Merck Manual, Dr. Fino, stated that he does not use it (EX 2, at 19). Nor did the Claimant move for the court to take judicial notice of the Merck Manual. Accordingly, it is not in evidence.

ORDER

IT IS ORDERED that the claim of Harold Dennison for black lung benefits is denied.

A

JEFFREY TURECK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2605, 200 Constitution Avenue, N.W., Washington, D.C. 20210.